MONTANA

The following are used for establishing reimbursement rates for Clinic Services:

I. Reimbursement for mental health clinic services will be made based on the lowest of: the provider's actual charge for the service, the Medicare amount allowed or the Department's fee schedule.

II. Reimbursement methodology for ambulatory surgical centers (ASC's) is based on the method of establishing ASC rates for Medicare found at 42 CFR part 416, subpart E (1997), and the schedule listing the allowable amounts for ASC services in rural counties found at Medicare Carriers Manual, section 5243. For ASC services where no Medicare fee has been assigned, the fee is 77% of usual and customary charges.

III. The methodologies for establishing the rates for diagnostic and evaluation services and public health services are the same as the methods used for physicians' services, psychologists' services, clinical social workers' services, physical therapy services, occupational therapy services, nurse specialists' services, speech therapy services and audiology services.

IV. Services provided by Indian Health Services and/or tribal 638 facilities are paid with federal funds according to rates proscribed by HCFA and established by the U.S. Public Health Service for Indian Health Services as set forth in the Federal Register. Subsequent payment adjustments will be made pursuant to changes published in the Federal Register.

V. Reimbursement for freestanding dialysis clinics or centers will be in accordance with 42 CFR 413, Subpart H (payment for End Stage Renal Disease (ESRD) services).

MONTANA

I. Reimbursement for Dental Services shall be the lowest of the following:

A. The provider's actual (submitted) charge for the service;
B. The amount allowable for the same service under Medicare (if applicable; or
C. The Department's fee schedule for dental services.

II. The Department's fee schedule is calculated as follows:

A. Dental procedures are identified through the following process:

1. Procedures identified through ADA/CDT coding manual; or

2. Dental procedures identified by the Department not identified in the current ADA/CDT.

B. Reimbursement rates are set by one of the following methods:

1. The fee is established at 80% of averaged charges for children 0 to 17 years of age and 65.2% of averaged charges for adults 18 years and older; or;

2. The fee is established at a different rate based on the Department's determination through its research that a different rate would better address access and utilization concerns.

3. For orthodontia services the fee is established at 85% of the provider's usual and customary charges per treatment phase. The department will initially pay 40% of the treatment phase with the remainder to be paid in equal payments over the treatment period.

MONTANA

I. Reimbursement for Physical Therapy Services shall be:

A. The lower of:

1. The provider's * usual and customary charge for the service, or
2. 90% of the reimbursement provided in accordance with the methodology described in Number II.

II. The Department's fee schedule for Physical Therapy Services is determined:

A. In accordance with the Resource Base Relative Value Scale (RBRVS) methodology, by multiplying Medicare's Relative Value Units (RVU), which is numeric, by the Montana Medicaid specific conversion factor, which is a dollar amount, to equal a fee. Specific to Montana Medicaid, there is an ability to multiply the fee times a policy adjuster (either plus or minus) to affect the fee including:

1. For state fiscal year 1998, no less than 85% of an nor more than 140% of the Medicaid fee for that procedure in state fiscal year 1997;
2. For state fiscal year 1999, no less than 80% of an nor more than 145% of the Medicaid fee for that procedure in state fiscal year 1997.

B. If there is not a Medicare RVU, Montana Medicaid will utilize history data to convert to an RVU.

C. If there is not a Medicare RVU or Medicaid history data, reimbursement will be 'by report'. 'By report' means paying a percentage of billed charges. The percentage is derived by dividing the previous state fiscal year's total Medicaid reimbursement for services included in the RBRVS by the previous state fiscal year's total Medicaid billings.

* A provider is a physical therapist licensed in the State of Montana who is enrolled in the Montana Medicaid program.

Attachment 4.19B
Methods & Standards
For Establishing
Payment Rates,
Service 11.b,
Occupational Therapy
Services

MONTANA

I. Reimbursement for Occupational Therapy Services shall be:

A. The lower of:
1. The provider's * usual and customary charge for the service; or
2. 90% of the reimbursement provided in accordance with the methodology described in Number II.

II. The Department's fee schedule for Occupational Therapy Services is determined:

A. In accordance with the Resource Base Relative Value Scale (RBRVS) methodology, by multiplying Medicare's Relative Value Units (RVU), which is numeric, by the Montana Medicaid specific conversion factor, which is a dollar amount, to equal a fee. Specific to Montana Medicaid, there is an ability to multiply the fee times a policy adjuster (either plus or minus) to affect the fee including:
1. For state fiscal year 1998, no less than 85% of and nor more than 140% of the Medicaid fee for that procedure in state fiscal year 1997;
2. For state fiscal year 1999, no less than 80% of and nor more than 145% of the Medicaid fee for that procedure in state fiscal year 1997.

B. If there is not a Medicare RVU, Montana Medicaid will utilize history data to convert to an RVU.

C. If there is not a Medicare RVU or Medicaid history data, reimbursement will be 'by report'. 'By report' means paying a percentage of billed charges. The percentage is derived by dividing the previous state fiscal year's total Medicaid reimbursement for services included in the RBRVS by the previous state fiscal year's total Medicaid billings.

* A provider is an occupational therapist licensed in the State of Montana who is enrolled in the Montana Medicaid program.

Attachment 4.19B,
Methods & Standards
For Establishing
Payment Rates,
Service 11.c
Speech Therapy &
Audiology Services

MONTANA

I. Reimbursement for Speech Therapy Services and Audiology Services shall be:

A. The lower of:
1. The provider's * usual and customary charge for the service; or
2. 90% of the reimbursement provided in accordance with the methodology described in Number II.

II. The Department's fee schedule for Speech Therapy Services and Audiology Services is determined:

A. In accordance with the Resource Base Relative Value Scale (RBRVS) methodology, by multiplying Medicare's Relative Value Units (RVU), which is numeric, by the Montana Medicaid specific conversion factor, which is a dollar amount, to equal a fee. Specific to Montana Medicaid, there is an ability to multiply the fee times a policy adjuster (either plus or minus) to affect the fee including:
1. For state fiscal year 1998, no less than 85% of and nor more than 140% of the Medicaid fee for that procedure in state fiscal year 1997;
2. For state fiscal year 1999, no less than 80% of and nor more than 145% of the Medicaid fee for that procedure in state fiscal year 1997.

B. If there is not a Medicare RVU, Montana Medicaid will utilize history data to convert to an RVU.

C. If there is not a Medicare RVU or Medicaid history data, reimbursement will be 'by report'. 'By report' means paying a percentage of billed charges. The percentage is derived by dividing the previous state fiscal year's total Medicaid reimbursement for services included in the RBRVS by the previous state fiscal year's total Medicaid billings.

* A provider is a speech-language pathologist licensed in the State of Montana who is enrolled in the Montana Medicaid program or an audiologist licensed in the State of Montana who is enrolled in the Montana Medicaid program.

MONTANA

Methods & Standards
for Establishing
Payment Rates,
Services 12 a.,
Outpatient Drug Services

Reimbursement for drugs shall not exceed the lowest of:

1. The Estimated Acquisition Cost (EAC) of the drug plus a dispensing fee, or;

2. The Federal Upper Limit (FUL), Maximum Allowable Cost (MAC) of the drug, in the case of multi-source (generic), plus a dispensing fee, or;

3. The provider's usual and customary charge of the drug to the general public.

Exception: The FUL or MAC limitation shall not apply in a case where a physician certifies in his/her own handwriting the specific brand is medically necessary for a particular recipient. An example of an acceptable certification is the handwritten notation "Brand Necessary" or "Brand Required." A check off box on a form or rubber stamp is not acceptable.

e EAC is established by the state agency using the Federal definition of .C as a guideline: that is, "Estimated Acquisition Cost" means the state agency's best estimate of what price providers generally pay for a particular drug.

The EAC, which includes single source, brand necessary and drugs other than multi-source, is established using the following methodology:

Drugs paid by their Average Wholesale Price (AWP) will be paid at AWP less 10%. The policy for the reimbursement of Direct Price (DP) drugs (the price charged by manufacturers to retailers) is the current direct price (the direct price in effect on the date of service for the claim.

The MAC for multiple source drugs will not exceed the total of the dispensing fee established by the Department and an amount that is equal to 150 percent of the price established under the methodology set forth in 42 CFR 447.331 and 447.332 for the least costly therapeutic equivalent.

A variable dispensing fee will be established by the state agency, by using the results of a cost survey of pharmacy's operational costs. A pharmacy may be assigned an enhanced dispensing fee to cover the additional costs associated with packaging "unit dose" prescriptions.

Provider dispensing fee(s) are available on-line in the Medicaid Management Information System (MMIS) provider file and in the Medicaid Prescription Drug ?ard System (PDCS) provider plan file.

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Montana

I. Reimbursement for Denture Services shall be the lowest of the following:

A. The provider's actual(submitted) charge for the service;
B. The amount allowable for the same service under Medicare (if applicable); or
C. The Department's fee schedule for denture services.

II. The Department's fee schedule is calculated as follows:

A. Denture procedures are identified through the following process:

1. Procedures identified through ADA/CDT coding manual; or
2. Denture procedures identified by the Department not identified in the current ADA/CDT.

B. Reimbursement rates are set by one of the following methods:

1. The fee is established at 80% of averaged charges for children 0 to 20 years of age per EPSDT requirements and 65.2% of averaged charges for adults 21 years and older. This fee-setting methodology also applies to newly established denture procedures identified through annual changes to the ADA/CDT procedure codes unless it is otherwise determined that a different reimbursement rate is necessary for access and utilization concerns.

Attachment 4.19B,
Methods & Standards
for Establishing
Payment Rates,
Service 12.c,
Prosthetic Devices

MONTANA

I. Reimbursement for Prosthetic Devices shall be the lowest of the following:

A. For those services not also covered by Medicare:

1. the provider's actual (submitted) charge for the service; or
2. the Department's fee schedule.

B. For those services also covered by Medicare:

1. the provider's actual (submitted) charge for the service;
2. the amount allowable for the same service under Medicare; or
3. the Department's fee schedule.

II. In determining upper limits of reimbursement for Prosthetic Devices:

A. The provider's actual charge is the amount submitted on the claim to Medicaid.

B. The amount allowable for the same service under Medicare is obtained from the Medicare Part B Carrier.

C. The Department's fee schedule has two components:

1. Specified fees for:

Prosthetic Devices for which there is a statistically significant volume* during the calendar year preceding the fiscal review year.

2. Percentage of billed charges for Prosthetic Devices for which there is not a statistically significant volume or which includes variable modifications. These are reimbursed at 90% of billed charges or no more than the manufacturers 1980 suggested retail price.

Attachment 4.19B,
Methods & Standards
for Establishing
Payment Rates,
Service 12.c,
Prosthetic Devices

* A statistically significant volume of services is a number of services billed to the medicaid program during a calendar year which will provide sufficient data for calculating a reasonable prevailing charge, using the Medicaid methods. The data for items which fifty bills have been received in a calendar year will be reviewed for possible fee determination within the state fiscal biennium.

Attachment 4.19B
Methods & Standards For
Establishing Payment Rates,
Service 12.c,
HEARING AIDS

MONTANA

I. Reimbursement for Hearing Aid Services (EXCLUDING HEARING AID(S) shall be the lower of the following:

a. The provider's* usual and customary charge for the service, or

b. The Department's fee schedule.

II. Reimbursement for Hearing Aid(s) shall be:

a. The invoice cost from the manufacturer not to exceed $400 for a monaural hearing aid and $800 for binaural hearing aids.

b. The invoice cost from the manufacturer for hearing aid repairs.

III. The Department's fee schedule is determined by:

a. Establishing a fee for each new service which has been billed at least 50 times by all providers in the aggregate during the previous 12 month period. The Department shall set each fee at 90% of the average charge billed by all providers in the aggregate.

b. Once a fee has been established, the Department will not adjust that fee except as allowed by increased funding through the state's legislative process.

*A provider is a licensed hearing aid dispenser who is individually enrolled in the Montana Medicaid program.